

STATE OF UTAH
DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING

APPLICATION FOR LICENSURE

PHYSICIAN ASSISTANT
NOTIFICATION OF CHANGE

DOPL-AP-091 REV 06/28/2002

APPLICATION INSTRUCTIONS AND INFORMATION

General Statement: The Division desires to provide courteous and timely service to all applicants for licensure. To maximize its efficiency and level of service, the Division will process complete applications only. **A complete application includes all applicable supporting documents.** The fees are for processing your application and will not be refunded. Failure to complete the application and supply necessary information will delay processing and may result in denial of licensure. Please read all instructions carefully.

Address of Record: The address listed on the application will be your address of record. All correspondence from the Division will be sent to that address. It is your responsibility to directly notify the Division of any change in address. Also, please note, the address of record is public information, available upon request and via the Internet. You may choose to use a business address or a post office box for your address of record rather than your home address.

Social Security Number: Your social security number is classified as a private record pursuant to Title 63, Chapter 2, Utah Government Records Access and Management Act (GRAMA). It is used as an individual identifier for our licensing database and for purposes of the child support enforcement pursuant to Subsection 78-32-17(3) and is mandatory pursuant to Subsection 58-1-301(1), Utah Code Ann., which implements the requirements of 42 U.S.C. 666(a)(13). An application that does not include a social security number is incomplete and cannot be processed.

ADDITIONAL IMPORTANT INFORMATION:

1. **Laws and Rules:** You are responsible to understand all laws and rules pertaining to your practice. The following applicable laws and rules are available on the Internet at www.dopl.utah.gov.

- ☐ Division of Occupational & Professional Licensing Act
- ☐ General Rules of the Division of Occupational and Professional Licensing
- ☐ Utah Physician Assistant Practice Act
- ☐ Utah Physician Assistant Practice Act Rules
- ☐ Utah Controlled Substances Act
- ☐ Controlled Substance Act Rules of the Division of Occupational and Professional

Licensing

- ❑ Health Care Providers Immunity from Liability Act

You may also purchase them from Exporior, 5486 South 1900 West, Suite C, Taylorsville, Utah 84118, (801) 355-5009.

2. **Notification of Change:** This form must be submitted to the Division and approval must be granted **prior** to your adding or changing supervising physicians. The supervising physician shall provide supervision to the physician assistant to adequately serve the health needs of the practice population and ensure the patients' health, safety, and welfare will not be adversely compromised.
3. **Delegation of Services Agreement:** A current "Delegation of Services Agreement" (attached to this application) is to be maintained at each of your Utah practice sites and must be available to the Division upon request.

Do not submit the Delegation of Services Agreement(s) with this application.

The agreements contain written criteria jointly developed by you and your supervising physician and substitute supervising physicians that permit you, working under the direction or review of the supervising physicians, to assist in the management of illnesses and injuries common to the physician's scope of practice.

4. **Mail Complete Application to:**

By U.S. Mail

Division of Occupational & Professional Licensing
P.O. Box 146741
Salt Lake City, Utah 84114-6741

By Delivery or Express Mail

Division of Occupational & Professional Licensing
160 East 300 South, 1st Floor Lobby
Salt Lake City, Utah 84111

5. **Telephone Numbers:** (801) 530-6628

(866) ASK-DOPL – Toll-free in Utah
(866) 275-3675
6. **Fax Number:** (801) 530-6511

APPLICATION FOR LICENSE or CERTIFICATE or REGISTRATION

GENERAL INFORMATION

License/Certificate/Registration Applying For: _____

Social Security Number: _____

Last Name: _____ Maiden Name: _____

First Name: _____ Middle Name: _____

Gender (Male or Female): _____ Date of Birth: _____

Have You Ever Held A Utah License Before? Yes _____ No _____

If Yes, Name of Profession: _____

If Yes, License Number: _____

PUBLIC MAILING ADDRESS

Street: _____

City: _____ State: _____ Zip: _____

County: _____

Telephone: _____

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY

License/Certificate Number: _____

Date License/Certificate Approved: _____

Approved By: _____

Date License/Certificate Denied: _____

Denied By: _____

Reason For Denial/Other Comments: _____

CURRENT SUPERVISION:

Complete the following for each CURRENT practice site. Use additional sheets if necessary.

Supervising Physician's Name: _____

License Number: _____ Specialty: _____

Number of physician assistants being supervised (including this applicant): _____

Number of FTE physician assistants: _____

Practice Site(s): _____

Type of Practice: _____

Percent of Direct Supervision: _____

Substitute Supervising Physician's Name: _____

License Number: _____ Specialty: _____

Supervising Physician's Name: _____

License Number: _____ Specialty: _____

Number of physician assistants being supervised (including this applicant): _____

Number of FTE physician assistants: _____

Practice Site(s): _____

Type of Practice: _____

Percent of Direct Supervision: _____

Substitute Supervising Physician's Name: _____

License Number: _____ Specialty: _____

PROPOSED SUPERVISION:

Complete the following for each PROPOSED practice site. Use additional sheets if necessary.

Supervising Physician's Name: _____

License Number: _____ Specialty: _____

Number of physician assistants being supervised (including this applicant): _____

Number of FTE physician assistants: _____

Practice Site(s): _____

Type of Practice: _____

Percent of Direct Supervision: _____

Substitute Supervising Physician's Name: _____

License Number: _____ Specialty: _____

Supervising Physician's Name: _____

License Number: _____ Specialty: _____

Number of physician assistants being supervised (including this applicant): _____

Number of FTE physician assistants: _____

Practice Site(s): _____

Type of Practice: _____

Percent of Direct Supervision: _____

Substitute Supervising Physician's Name: _____

License Number: _____ Specialty: _____

SUMMARY:

Following the addition and/or deletion of the changes requested above, please list all of your supervisors as a result of these changes. Use additional sheets if necessary.

Name: _____	<input type="checkbox"/> Primary	<input type="checkbox"/> Substitute
Name: _____	<input type="checkbox"/> Primary	<input type="checkbox"/> Substitute
Name: _____	<input type="checkbox"/> Primary	<input type="checkbox"/> Substitute
Name: _____	<input type="checkbox"/> Primary	<input type="checkbox"/> Substitute
Name: _____	<input type="checkbox"/> Primary	<input type="checkbox"/> Substitute
Name: _____	<input type="checkbox"/> Primary	<input type="checkbox"/> Substitute

AFFIDAVIT:

I declare under penalty of perjury as follows:

I will be practicing as a physician assistant in Utah. I have completed a "Delegation of Services Agreement" with my supervising physician and have reviewed the agreement with each of my substitute supervising physicians.

A copy of the agreement is on file at each of my Utah practice sites and is available to the Division upon request.

The agreement defines the working relationship and delegation of duties between me and my supervising physician and includes all of the following: the prescribing of controlled substances; the degree and means of supervision; the frequency and mechanism of chart review; procedures addressing situations outside my scope of practice; and procedures for providing backup for me in emergency situations. The written criteria were jointly developed by me and my supervising physician and by me and any substitute supervising physicians. The agreement permits me to work under the direction or review of my supervising physician(s) to assist in the management of illnesses and injuries common to the physician's scope of practice.

Signature of PA Applicant: _____

Date of Signature: _____

Signature of Supervising Physician: _____

Date of Signature: _____

PHYSICIAN ASSISTANT DELEGATION OF SERVICES AGREEMENT

A Delegation of Services Agreement is to be maintained at each practice site and is to be available to the Division upon request. It consists of written criteria jointly developed by a physician assistant's supervising physician and any substitute supervising physicians and the physician assistant that permits a physician assistant, working under the direction or review of the supervising physicians, to assist in the management of illnesses and injuries common to the physician's scope of practice.

The following information must be legible. Use additional sheets if necessary.

DO NOT SUBMIT YOUR DELEGATION OF SERVICES AGREEMENTS TO THE DIVISION WITH YOUR APPLICATION FOR LICENSURE.

Physician Assistant Name: _____

Supervising Physician Name: _____

Utah License Number: _____

Substitute Supervising Physician(s):

Name: _____ Utah License Number: _____

Name: _____ Utah License Number: _____

Name: _____ Utah License Number: _____

Name: _____ Utah License Number: _____

PRACTICE SITE(S):

1. Name of Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

2. Name of Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

DEGREE AND MEANS OF SUPERVISION:

The supervising physician shall provide supervision to the physician assistant to adequately serve the health care needs of the practice population and ensure that the patient's health, safety, and welfare will not be adversely compromised. There shall be a method of immediate consultation by electronic means whenever the physician assistant is not under the direct supervision of the supervising physician. A physician assistant holding a temporary license may work only under 100% direct supervision. There shall be a method of immediate consultation by electronic means whenever the physician assistant is not under the direct supervision of the supervising physician.

FREQUENCY AND MECHANISM OF CHART REVIEW:

The degree of onsite supervision shall be outlined in the Delegation of Services Agreement maintained at the site of practice. Physician assistants may authenticate with their signature any form that may be authenticated by a physician signature.

PRESCRIBING OF CONTROLLED SUBSTANCES:

A physician assistant may prescribe or administer an appropriate controlled substance if the physician assistant holds a current Utah controlled substance license covering the appropriate schedules of controlled substances and a current DEA registration covering the appropriate schedules of controlled substances; the prescription or administration of the controlled substance is within the prescriptive practice of the supervising physician and also within the delegated prescribing stated in the delegation of services agreement; and the supervising physician co-signs any medical chart record of a prescription of a Schedule 2 or Schedule 3 controlled substance made by the physician assistant.

In order to prescribe controlled substances, the physician assistant must have obtained his or her own controlled substance license and DEA registration. The physician assistant may not use his or her supervising physicians' controlled substance licenses or DEA registrations.

PROCEDURES ADDRESSING SITUATIONS OUTSIDE THE PHYSICIAN ASSISTANT'S SCOPE OF PRACTICE:

**PROCEDURES FOR PROVIDING BACKUP FOR THE PHYSICIAN ASSISTANT IN
EMERGENCY SITUATIONS:**

ADDITIONAL CONSIDERATIONS RELATING TO OUR PRACTICE:

Signature of Physician Assistant: _____

Date of Signature: _____

Signature of Supervising Physician: _____

Date of Signature: _____

Signature of Substitute Supervising Physician: _____

Date of Signature: _____

NOTE: It is “unprofessional conduct” under the Physician Assistant Practice Act to fail to maintain at the practice site(s) a “Delegation of Services Agreement” that accurately reflects current practices; or to fail to make the “Delegation of Services Agreement” available to the Division for review upon request.